Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
TASB RISK MANAGEMENT FUND

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-10-0950-01

MFDR Date Received
October 9, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After initial/request for reconsideration receipt of medical bill Carrier provided code 'W12'. Specifically, the Carrier di not attach a PLN-11 (TWCC-21) . . . Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A)"

Amount in Dispute: $4,185.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The surgeon properly requested two different pre-authorizations for two different dates of injury. . . . There is no rule stating a PLN 11 is to be distributed to a provider who is not involved in the original treatment of the disputed condition . . . As they were notified that the two conditions treated were due to different injuries, the fact that dispute was in force for one of the conditions on the opposite claim is not sufficient grounds for filing an MDR. . . . After receiving notice that an MDR was filed, we notified Vista Hospital . . . asking them to separate the charges for the two injures and we would process the bill to pay benefits for the previously excluded charges. . . . After receiving permission . . . to do so, we re-entered the bill to the correct date of injury. Since the denied surgery was done in the same operative session as the surgery previously paid, we are basing the allowable on Medicare's schedule, upgrading it in compliance with DWC rules (200%), and paying it at 50% according to the multiple surgery rules.. . . The Fund feels we have taken the necessary steps to resolve this matter."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2008 to October 15, 2008	Outpatient Hospital Services	$4,185.55	$362.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - W12, 197 – Extent o f injury. Not finally adjudicated . . . Payment denied reduced for absence of precertification/authorization . . . Not related to compensable injury of left shoulder . . . Pre-auth was for shoulder surgery only . . . PLN 11 filed disputed treatment for carpal tunnel, not related to injury.
   - 18 – Duplicate claim/service. . . . Duplicate to EOMB#1749481, processed on date of injury 3/15/04. Done in the same operative session. 2 different dates of injuries.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment. . . . Duplicate to EOMB#1749481, processed on date of injury 3/15/04. Done in the same operative session. 2 different dates of injuries.

Issues

1. Is there a dispute as to the extent of injury, compensability, or liability related to the services in dispute?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason codes W12, 197 – "Extent o f injury. Not finally adjudicated . . . Payment denied reduced for absence of precertification/authorization . . . Not related to compensable injury of left shoulder . . . Pre-auth was for shoulder surgery only . . . PLN 11 filed disputed treatment for carpal tunnel, not related to injury." Upon reconsideration, the insurance carrier did not maintain these denial reasons; the insurance carrier reviewed and issued payment for the services in dispute. The Division therefore finds that there are no longer any issues regarding extent, compensability or liability related to the services in this dispute, and the only issues remaining are the medical fee issues left to be adjudicated in this review.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J3490, date of service October 15, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code A4649 represents an item or service for which payment is bundled into payment for other services. Separate payment is not recommended.
- Procedure code A4649, date of service October 15, 2008, represents an item or service for which payment is bundled into payment for other services. Separate payment is not recommended.
- Procedure code A4649 represents an item or service for which payment is bundled into payment for other services. Separate payment is not recommended.
- Per Medicare policy, procedure code 29805 may not be reported with procedure code 23420 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment is not recommended.
- Procedure code 64721 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0220, which, per OPPS Addendum A, has a payment rate of $1,149.79. This amount multiplied by 60% yields an unadjusted labor-related amount of $689.87. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $677.18. The non-labor related portion is 40% of the APC rate or $459.92. The sum of the labor and non-labor related amounts is $1,137.10. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $568.55. This amount multiplied by 200% yields a MAR of $1,137.10.
- Procedure code 23420 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $2,737.89. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,642.73. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,612.50. The non-labor related portion is 40% of the APC rate or $1,095.16. The sum of the labor and non-labor related amounts is $2,707.66. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $2,251.00 yields a cost of $733.83. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $2,707.66 divided by the sum of all APC payments is 70.03%. The sum of all packaged costs is $4,962.10. The allocated portion of packaged costs is $3,475.11. This amount added to the service cost yields a total cost of $4,208.94. The cost of these services exceeds the annual fixed-dollar threshold of $1,575; however, the amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $2,707.66. This amount multiplied by 200% yields a MAR of $5,415.32.
- Procedure code 26055 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0053, which, per OPPS Addendum A, has a payment rate of $1,048.64. This amount multiplied by 60% yields an unadjusted labor-related amount of $629.18. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $617.60. The non-labor related portion is 40% of the APC rate or $419.46. The sum of the labor and non-labor related amounts is $1,037.06. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $518.53. This amount multiplied by 200% yields a MAR of $1,037.06.
- Procedure code 99144 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 94799 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0367, which, per OPPS Addendum A, has a payment rate of $36.16. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.70. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $21.30. The non-labor related portion is 40% of the APC rate or $14.46. The sum of the labor and non-labor related amounts is $35.76. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific

reimbursement amount for this line is $35.76. This amount multiplied by 200% yields a MAR of $71.52.

- Per Medicare policy, procedure code 94762 may not be reported with procedure code 99144 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 94799, date of service October 15, 2008, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0367, which, per OPPS Addendum A, has a payment rate of $36.16. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.70. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $21.30. The non-labor related portion is 40% of the APC rate or $14.46. The sum of the labor and non-labor related amounts is $35.76. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $35.76. This amount multiplied by 200% yields a MAR of $71.52.
- Per Medicare policy, procedure code 99205 may not be reported with procedure code 99144 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0378, date of service October 15, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

5. The total allowable reimbursement for the services in dispute is $7,732.52. This amount less the amount previously paid by the insurance carrier of $7,369.92 leaves an amount due to the requestor of $362.60. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $362.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $362.60, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 20, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.